DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 1 0

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 16, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 0
b. FFY 04 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1 & 2, 30 & 31, 33 - 36, 38, 41, & 44 , & 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 1 & 2, 2a, 30 & 31, 33 - 36, 38, 41, & 44
Iowa (03-010)
Approved: 02/2/04
Effective: 07/16/03

10. SUBJECT OF AMENDMENT:
Clarifies reimbursement methodology for hospital outpatient services, based on ambulatory patient groups (APG's)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W Concannon

13. TYPED NAME:
Kevin W. Concannon

14. TITLE:
Director

15. DATE SUBMITTED:
July 24, 2003

16. RETURN TO:
Director
Iowa Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 30, 2003

18. DATE APPROVED:
FEB 20 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 16 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lentz

22. TITLE:
Acting Regional Administrator for Medicaid

23. REMARKS:

SPA CONTROL
Date Submitted: 07/25/03
Date Received: 07/30/03

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

The following services are reimbursed on the basis of a fee schedule established by the Department following negotiations with representatives of the provider group involved plus periodic percentage adjustments.

- Ambulance services
- Area education agencies
- Audiologists
- Birth centers
- Chiropractors
- Clinics
- Community mental health centers
- Dentists
- Durable medical equipment, prosthetics and orthotics, and sick room supplies
- Family and pediatric nurse practitioners
- Family planning centers
- Hearing aid dispensers
- Infant and toddler programs
- Lead investigation agencies
- Local education agencies
- Nurse midwives
- Opticians
- Optometrists
- Orthopedic shoe dealers
- Physical therapists in independent practice
- Physicians
- Podiatrists
- Psychologists
- Screening centers (EPSDT)
- Transportation to receive necessary medical care

Ambulatory Surgical Centers, Independent Laboratories, and Rehabilitation Agencies

The basis of payment for ambulatory surgical centers is a fee schedule, as determined by Medicare, of the fee in effect on June 30, 2003, effective July 1, 2003. The basis for payment for independent laboratories and rehabilitation agencies is a fee schedule, as determined by Medicare.

Home Health Agencies

The basis of payment for home health agencies is reasonable cost on a retrospective basis. EPSDT private duty nursing and personal care services provided by a home health agency are reimbursed on an hourly basis using an interim fee schedule established by the Department. Vaccines for Children (VFC) is reimbursed on a vaccine administration interim fee schedule based on the physician fee schedule. EPSDT private duty nursing and personal care services and VFC services are retrospectively cost-settled.

Maternal Health Centers

The basis of payment for maternal health centers is reasonable cost on a prospective basis, as determined by the Department based on financial and statistical information submitted by the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Clinic Services

The basis of payment for clinics is fee schedule based on the physician and dentist fee schedule. The basis of payment for free-standing renal dialysis clinics is a fee schedule based on professional recommendations and Departmental review.

Certified Registered Nurse Anesthetists (CRNAs)

Reimbursement for CRNA services is made using the HCFA fee schedule (CPT-4) anesthesiology procedure list and associated base units. When the CRNA receives medical direction from the surgeon, reimbursement to the CRNA is 80% of the amount which would be paid to an anesthesiologists (MD or DO). When the CRNA receives medical direction from an anesthesiologist, reimbursement to the CRNA is 60% of what an anesthesiologist would receive for the same procedure.

Adjustment of Payment Rates

Reimbursement changes effective July 1, 2003, include:

- Rates for hospital services will remain the same as the rates in effect on June 30, 2003.
- Rates for the following providers and services will remain the same as rates in effect on June 30, 2003.

  - Ambulance
  - Birth centers
  - Certified registered nurse anesthetists
  - Community mental health centers
  - Dentists
  - Durable medical equipment, prosthetics, orthotics, and sickroom supplies
  - Family planning clinics
  - Home health agencies
  - Hearing aid dispensers
  - Lead inspection agencies
  - Maternal health centers
  - Opticians
  - Orthopedic shoe dealers
  - Screening centers

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Adjustment of Payment Rates (Cont.)

Reimbursement changes effective July 1, 2003, under the Iowa Medicaid fee schedule established using the resource-based relative value scale (RBRVS) methodology shall remain the rate in effect on June 30, 2003, for the following providers:

- Audiologists
- Chiropractors
- Clinics
- Family and pediatric nurse practitioners
- Nurse midwives
- Optometrists
- Physical therapists
- Physicians (MD and DO)
- Podiatrists
- Psychologists

Psychiatric Institutions for Children

Inpatient services provided by psychiatric medical institutions for children are reimbursed on the basis of actual cost as established under the Department's purchase of service system. Effective July 1, 2003, psychiatric medical institutions for children will be reimbursed on per diem rates for actual costs on June 30, 2003, not to exceed $147.20 a day.

Outpatient day treatment services provided by a psychiatric medical institution for children are reimbursed on a per diem basis of the rate in effect on June 30, 2003, effective July 1, 2003.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

"APG relative weight" means a number that reflects the expected resource consumption for cases associated with each APG, relative to the average APG. That is, the Iowa-specific weight for a certain APG reflects the relative charge for treating all singleton cases classified in that particular APG, compared to the average charge for treating all Medicaid APGs in Iowa hospitals.

"Assessment payment" means an additional payment made to a hospital for only the initial assessment and determination of medical necessity of a patient, for the purpose of determining if the emergency room is the most appropriate treatment site. This payment is equal to 50 percent of the customary reimbursement rate for CPT-4 code 99281 (evaluation and management of a patient in the emergency room), as of December 31, 1994.

"Base year cost report" means the hospital's cost report with a fiscal-year-end on or after January 1, 2001, and before January 1, 2002. Cost reports are reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" means the case-mix-adjusted, hospital-specific operating cost per visit associated with treating Medicaid outpatients, plus the statewide average case-mix-adjusted operating cost per Medicaid visit, divided by two. This basic amount is the value to which inflation is added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report are not used in determining the statewide average case-mix-adjusted operating cost per Medicaid visit.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.

"Case-mix index" means an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Consolidation" means the process by which the APG classification system determines whether separate payment is appropriate when a patient is assigned multiple significant-procedure APGs. All significant procedures within a single APG are suppressed (or consolidated) for payment purposes, except one. Multiple, related significant procedures in different APGs are consolidated into the highest weighted APG for reimbursement purposes. Multiple, unrelated significant procedures are not consolidated; thus, each receives separate payment.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

"Cost outlier" means a case that has an extraordinarily high cost and thus is eligible for additional payment above and beyond the base APG payment.

"Current Procedural Terminology - Fourth Edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rule is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discounting" means a reduction in the standard payment when multiple procedures or ancillaries are performed during a single visit. Discount rates are defined in Section 10.

"Final payment rate" means the blended base amount that forms the final dollar value used to calculate each provider's reimbursement amount, when multiplied by the APG weight. These dollar values are displayed on the rate table listing.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs associated with the operation of graduate medical education programs.

"Grouper" means the Version 2.0 Grouper software developed by 3M Health Information Systems for CMS, for payable APGs made to support Medicaid program policy in Iowa.

"Inlier" means a case where the cost of treatment falls within the established cost boundaries of APG payment.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

"Risk corridor" means payment limits to prevent immediate large financial gains or losses for Iowa hospitals due to APG implementation.

"Significant-procedure APG" means a procedure which is normally scheduled, which constitutes the reason for the visit, and which dominates the time and resources expended during the visit.

"Singleton APG" means those APGs on a patient claim which, following consolidation of significant procedures and packaging of ancillaries, are part of a visit with no remaining multiple significant procedures. Singletons, as well as medical and ancillary visits, are used to calculate relative weights in the procedure described in Section 7.b.

"Statewide visit expected payment (SVEP)" means the expected payment for an outpatient visit, for use in defining cost outliers. This payment equals the sum of the statewide average case-mix-adjusted operating cost per Medicaid visit multiplied by the relative weight for each valid APG within a visit (following packaging and discounting), which includes the applicable fee schedule amounts.

"Valid claims or visits" means those claims or visits that are priced and paid using the ambulatory patient group (APG) system.

3. Services Covered by APG Payments

Medicaid adopts the Medicare definition of outpatient hospital services, which are covered by the APG-based prospective payment system, except as indicated herein. Claims for outpatient NIP services, ambulance, clinical laboratory, and observation bed stays are not reimbursed through APG payment. (See Section 14 regarding these services.)

Iowa Medicaid does not accept claims for payment for the following APGs, as defined in Version 2.0 of the CMS-funded development project: APG 005, nail procedures; APG 171, artificial fertilization; APG 212, fitting of contact lenses; APG 386, biofeedback and other training; and APG 382, provision of vision aids.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

These services are not services typically provided in an outpatient setting and are often services that are not eligible for payment by Iowa Medicaid or require additional approval, editing, or certification from another source. Upon the provider's request, any service performed that groups into one of the above APGs may be reviewed for appropriateness of payment if the claim has been denied.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per APG and the statewide average cost per APG can be determined by using the individual hospital's 2001 Medicare Cost Report (CMS 2552), Worksheet OP-1, as submitted to the state. The total numbers of Medicaid visits were determined from the use of submitted claims data.

The base-year cost for the current rebasing is the hospital's 2001 fiscal year end. The rates have been trended forward using inflation indices of 0.0% for SFY 1999, 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0.0% for SFY 2003 and 0.0% for SFY 2004. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

a. Calculation of Hospital-Specific and Statewide Medicaid Outpatient Visits

The total number of Medicaid outpatient visits was determined as the number of 2001 claims contained in the Medicaid Management Information System:

- Less the number of visits associated with services provided under the NIP programs,
- Less the visits associated with an ambulance claim (if the claim was a single line item),
- Less the visits associated with observation beds (if the claim was a single line item), and
- Less the visit for the provision of referred clinical laboratory testing (if the claim was a singleton claim for a referred test).

The remaining number of visits was then inflated to account for an increased number of eligibles and increased volume of services in accord with state budgetary projections. This number is known as the hospital-specific number of outpatient visits. To arrive at the statewide number of visits, all hospital-specific numbers of visits are summed.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

b. Calculation of Statewide Average (Case-Mix-Adjusted) Cost Per Visit

The statewide average case-mix-adjusted cost per visit is calculated by taking:

	Statewide total Iowa Medicaid outpatient expenditures
Less	The total dollar expenditures for interns and residents costs, based on all hospitals' base-year cost reports
Less	The calculation of actual, projected payments that will be made for outliers, fee-scheduled clinical laboratory tests, noninpatient programs (see Section 14, part b), ambulance services, and observation beds.
	The remaining amount is case-mix adjusted, then is
Multiplied by	The inflation update factor, and
Divided by	The statewide total net number of valid Medicaid outpatient visits.
The result is:	The statewide average case-mix-adjusted cost per visit.

Data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted cost per visit.

c. Calculation of Hospital-Specific Case-Mix-Adjusted Average Cost Per Visit

As determined from the 2001 base year cost report, the hospital-specific case-mix adjusted average cost per visit is calculated by taking:

	The lesser of total 2001 Iowa Medicaid costs or covered reasonable charges for each hospital except those receiving reimbursement as critical access hospitals
Less	The actual dollar expenditures for direct medical education costs
Less	The actual dollar costs for outliers, fee-scheduled laboratory tests, and noninpatient programs (see section 14, part b), observation beds, and ambulance
Divided by	The hospital-specific case-mix index
Multiplied by	The inflation update factor
Divided by	The total number of hospital-specific valid Medicaid outpatient visits
Equals	The hospital-specific case-mix-adjusted cost per visit.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

d. Calculation of the Blended Statewide and Hospital-Specific Base Amount

The APG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts. To arrive at a 50/50 blended base amount, the hospital-specific case-mix-adjusted average cost per visit is added to the case-mix-adjusted statewide average cost per visit, and the total is divided by two.

e. Determination of Final Payment Rate Amount

Each hospital's APG-based payment equals the hospital's blended base amount multiplied by the APG weight.

5. Calculation of the Direct Medical Education Component

The reimbursement for direct medical education is allocated to the Graduate Medical Education and Disproportionate Share Fund and is not paid on a per-claim basis. The requirements to receive payments from the fund, the amount allocated to the fund, and the methodology used to determine the distribution amounts from the fund are found in Section 24.

6. The Inflation Update Index and Annual Update

Inflation of base payment amounts by the Data Resources, Inc., hospital market basket index shall be performed annually, subject to legislative appropriations.

7. Explanation of Iowa-Specific Relative Weights

An APG weight is a relative value associated with the charge for conducting an outpatient procedure or medical visit, as compared to that of the average or mean procedure or visit.

Iowa-specific relative APG weights have been calculated using applicable claims for the period January 1, 2000, through December 31, 2001, paid through March 31, 2002. The calculation includes all normal inlier claims, as well as the inlier portion of cost outlier claims. This second component is known as "trimmed claims." Claims of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report are not used in calculating Iowa-specific relative weights.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

(4) Relative weights for APGs that had low or no volume in the claims data and weights that were deemed too high or low by a committee of clinicians assembled by the Iowa Foundation for Medical Care are administratively adjusted.

(5) The relative weights are then normalized, so that the average case has a weight of one.

c. Calculation of the Hospital-Specific Case-Mix Index

The hospital-specific case-mix index is computed by summing the relative weights for each valid occurrence of an APG at that hospital and dividing by the number of valid Medicaid visits for that hospital. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

8. Calculation of Hospital-Specific APG Payment

The final payment rate, as defined in Section 4, is used to determine the final payment amount made to a hospital, subject to the discounting, outlier, and direct medical education policies described in this document. The final payment rate is multiplied by the weight associated with each of the patient's assigned APGs.

The product of the final payment rate times the APG weight results in the total dollar reimbursement made to a hospital on a claim basis. This reimbursement amount may be further adjusted according to the policies relating to discounting, packaging, consolidation of APGs, or payment of outlier reimbursement before the actual payment.

9. Discounting Policy

The purpose of reducing standard payment for multiple procedures or ancillaries in a single visit is to encourage efficient provision of these services. The discount factor reflects the fact that fixed costs are reduced for multiple procedures performed in the same setting at the same time. Examples of such fixed costs are operating room charges, anesthesia, and specimen collection.

Claims for multiple medical visits within a 72-hour period and claims for services billed in "batches" (such as dialysis and chemotherapy) are not subject to discounted payment.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

11. Recalibration of Iowa-Specific Weights and Rebasing of Base Amounts

Iowa-specific weights have been computed by using UB-92 charge data submitted by providers for claims between January 1, 2000, and December 31, 2001, and paid through March 31, 2002. These APG weights are recalibrated in 2005 and every three years thereafter. All hospitals' base amounts, except those receiving reimbursement as critical access hospitals, are rebased according to this same schedule.

12. Cost Reporting

Cost reports used in rebasing will be hospital fiscal year-end form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission timelines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report to the Medicaid fiscal agent by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the fiscal agent of Iowa within 150 days after the close of the hospital's fiscal year.

13. Incentives

Payment to hospitals using the APG methodology extends the same incentives for efficiency of operations to the outpatient setting which are inherent to the DRG methodology. This system encourages providers to control their operating costs and hence, lower their actual overall costs for Medicaid.

When the covered charge is lower than the hospital's prospective reimbursement rate, the hospital is allowed to keep the difference. When the reverse is true, the hospital will not experience additional payment for that service.

Under 42 CFR 447.321, upper payment limit tests are required to ensure that Medicaid payments made under this plan do not exceed what would be paid for the services furnished by the group of facilities under Medicare payment principles. This applies to rates paid for outpatient services furnished by hospitals within the following categories:

- State government-owned or operated,
- Non-state-government-owned or operated, and
- Privately-owned and operated.

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

a. Bills for multiple visits may be submitted on a single claim for the following services: noninpatient units (substance abuse, pain management, nutritional counseling, diabetic education, pulmonary rehabilitation, cardiac rehabilitation, eating disorders and mental health), physical, occupational and speech therapies, chemotherapy, radiation therapy, and renal dialysis. For these services, each unit of service on the UB-92 claim form will be considered a separate visit.

b. Bills for multiple medical encounters (for unrelated diagnoses), such as clinic visits, occurring within a 72-hour period shall be submitted on separate UB-92 claim forms in order to generate full APG payment for these encounters. In the case of hospital-based clinics where multiple, unrelated medical visits occur on the same day, an individual claim form will need to be filed for each separate visit.

16. Rate-Setting Processes for Out-of-State Hospitals

APG payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average case-mix adjusted base amount or the Iowa statewide average case-mix adjusted base amount blended with the hospital-specific base amount.

Hospitals that submit a cost report using data for Iowa Medicaid patients only, no later than May 31 in a rebasing year, will receive a case-mix-adjusted blended base rate using hospital-specific Iowa-only Medicaid data and the Iowa statewide average cost per visit amount. If a hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for reimbursement purposes in Iowa. Reimbursement is an allocated distribution from the Graduate Medical Education and Disproportionate Share Fund.